TENNESSEE DEPARTMENT OF HUMAN SERVICES
HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

Information will be released for: **PRINT NAME►**	**Date:**	**Identify Signer:** ☐ Self ☐Parent of minor ☐Guardian ☐Other authorized representative (explain) * Proof of legal authorization may be required.
Street Address		**(Parent/guardian sign here if two signatures required by State law)**

Phone Number (with area code) **( )**	**City**	**State**	**Zip**
Social Security Number – not required – may be used by some health care providers for identification		**Date of Birth**	

- **I give permission for the following records to be sent to the Tennessee Department of Human Services (TDHS) and its authorized agents/contractors. The records will be used to help decide eligibility for services or benefits.**
  - **TDHS may get any and all medical / health records: Yes:_____ No:_____ Initials: _____**
  - **TDHS may get any and all mental health records: Yes:_____ No:_____ Initials: _____**
  - **TDHS may get drug or alcohol treatment / referral records: Yes:_____ No:_____ Initials: _____**
  - **TDHS may get HIV / AIDS test / treatment records: Yes _____ No:_____ Initials: _____**
  - **Specific Description of any other medical / health information that may be provided: _____**

_____

- **The law requires specific identification of the person(s), <u>or</u> class of persons, from whom information can be requested. Choose one of the following below.**

  _____ (initials) I choose to identify specific persons / organizations from whom information can be requested. TDHS can get my medical / health information from only the following specified persons / organizations:

_____

_____

  _____ (initials) Rather than specifically identifying persons / organizations from whom information can be requested, I choose to permit TDHS to request information from the following <u>class</u> of persons / organizations: doctors, hospitals, clinics, nursing homes, any other private or government health care providers, insurance companies, and public or private health plans.

<u>YOU DO NOT HAVE TO SIGN THIS FORM.</u> ***If you do not sign this form, or if you take back your permission, TDHS may not be able to decide the case on time or may have to deny benefits.***

- TDHS may make copies of this form and may also use a computer, electronic and/or fax copy.
- You will get a copy of this form after you sign it. You can ask the doctor(s) or hospital(s) to let you see or copy the information sent to TDHS after you sign this form.
- **<u>This permission is good for 12 months from the date you sign this form, unless you take back your permission sooner</u>.**
- **<u>You have the right to withdraw your permission at any time</u>.** ***You cannot take back information that has been used to take action on your case or that has been given to us before you take back your permission.***
- **<u>To take back your permission, you can *write* TDHS in your county, or *write* your doctors, hospitals or other health care providers or insurance company or health plan to take back your permission at any time.</u>**
- All information provided to TDHS is protected by the Privacy Act of 1974 and federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out the information, it may not be protected if the person or organization that receives it is not required by law to protect the information.
- **We may also use your information when we compare records by computer.** The computer matches our information with other federal, state or local government agencies. Many agencies use matching information to find out if a person gets benefits paid by the federal or state government. The matches also help prove that a person is eligible for help. The law lets us do this even if you do not agree to it.
- <u>Ask TDHS to explain if you have questions about how or why your information is used.</u>

Signature of Person or Person's Authorized Representative: _____ Date: _____

Witness: _____ Date: _____

This authorization was developed to comply with the provisions regarding disclosure of medical/health information under P. L. 104-191 ("HIPAA"); 45 Code of Federal Regulations parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2.31; 38 U.S. Code section 7332 and T.C.A § 68-10-113.